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ABSTRACT

This training manual for emergency medical technicians, one of 14 modules that comprise the Emergency Victim Care textbook, covers crisis intervention and drug related problems. Objectives stated for the two chapters are for the student to be able to describe: treating common mental disturbances, relating to those suffering a crisis in a large-scale disaster, dealing with rape and suicide victims, treating basic drug reactions, and handling emergency care to treat drug overdose victims. Informative material is provided on care of the mentally disturbed and victims in crisis, care of emotionally disturbed people in large-scale emergencies, common mental disturbances, the rape victim, suicide, transportation of mentally disturbed persons, and caring for and treatment of drug-related victims. (YLB)

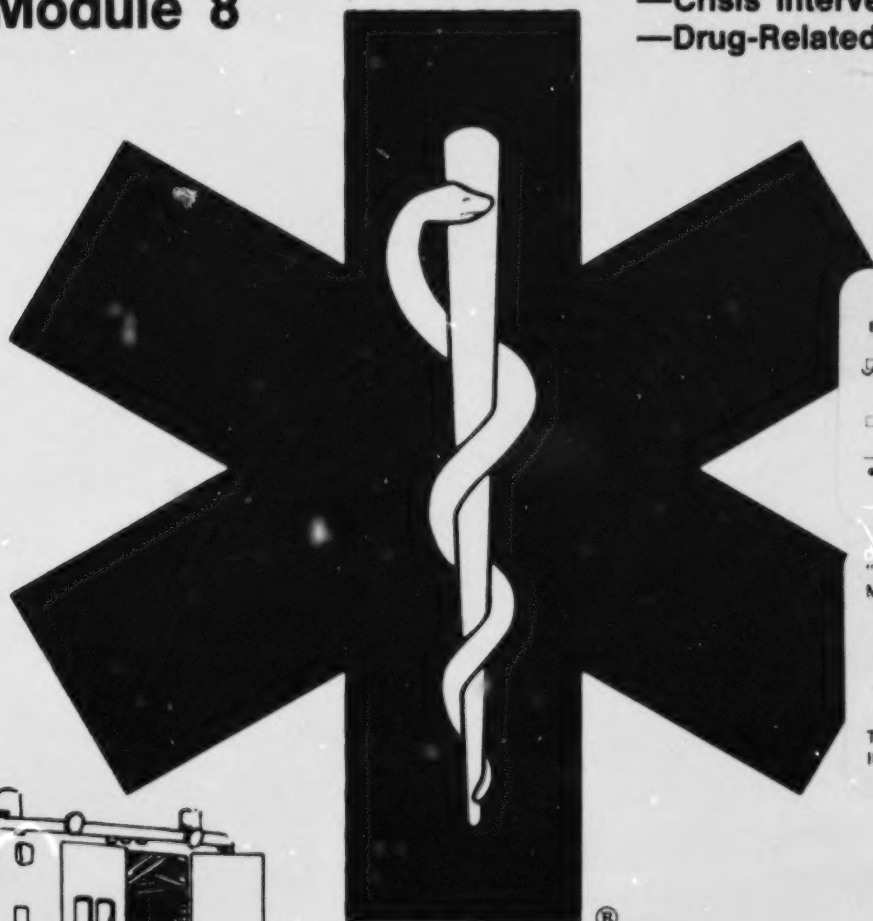
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EMERGENCY VICTIM CARE

Module 8

—Crisis Intervention
—Drug-Related Problems

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EMERGENCY VICTIM CARE

A TRAINING MANUAL FOR EMERGENCY MEDICAL TECHNICIANS

OHIO TRADE AND INDUSTRIAL EDUCATION SERVICE

**DIVISION OF VOCATIONAL EDUCATION
STATE DEPARTMENT OF EDUCATION
COLUMBUS, OHIO**

TO THE LEARNER

The 1983 Emergency Victim Care textbook revision has been grouped into 14 modules. The modules have been grouped by content matter as follows:

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EMS Communication
Records and Reports

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Legal Aspects
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Action Evaluation Conference

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Module 4

Vital Signs
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Module 6

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CRISIS INTERVENTION

OBJECTIVES

Upon completion of the following chapter, you will be able to:

- describe common mental disturbances.
- describe how to relate to those who suffer a crisis in a large-scale disaster.
- describe how to deal with the rape victim.
- describe how to deal with the suicide victim.

CARE OF THE MENTALLY DISTURBED AND VICTIMS IN CRISIS

Many times emergency medical personnel are called to attend a person who is behaving "oddly". It is paramount EMTs remember they are to assist disturbed people and *not* judge or punish them.

This chapter is divided into two parts. The first section explains the theory of and instructions for practicing crisis intervention. The second section describes various situations in which crisis intervention should be employed as a treatment of choice.

CRISIS INTERVENTION

All emergency situations are crises for the victims as well as their friends, relatives and possibly, bystanders. Often the EMT is confronted with a situation in which emotional support as well as medical treatment must be administered. In these situations the EMT must be able to act in a professional manner to gain the cooperation of those directly involved in the emergency.

Essentially there are four categories of calls confronting the EMT:

General emergencies

Emotionally charged emergencies

Emergencies involving the emotionally disturbed

Large-scale disasters

This chapter is designed to give the EMT information in dealing with intervention situations.

Crisis intervention can be defined as the helping response to a victim of crisis. Such intervention requires personnel to be alert, flexible, resourceful and professional in their behavior. The EMT should remember that a crisis is time limited in nature. It is a direct response to a situation which temporarily disrupts the emotional balance of the individual. The situation confronted by the individual is so threatening that normal coping mechanisms cannot provide the needed protection and a breakdown occurs. Most people who experience crises display the following six phases of emotional reactions.

1. High anxiety or emotional shock
2. Denial
3. Anger
4. Remorse
5. Grief
6. Reconciliation

In most situations the EMT will be confronted with the first phase: high anxiety or

emotional shock. In this state the victim tends to be highly unstable and emotional in nature. The victim's behavior is also excitable and unpredictable; therefore, the EMT must be sensitive to what is occurring and take control of the situation as quickly as possible. Victims of crises are vulnerable to permanent damage as a result of continued stress. Thus, assistance provided by the EMT during the initial phases of the crisis is often most significant in terms of the overall crisis.

In carrying out crisis intervention, the EMT must act with the highest level of professionalism. This means all prejudices must be set aside and are not permitted to interfere with treatment of the victim. The EMT must remember to assist the victim in crisis, not punish the person for the behavior exhibited. Further, the EMT must be in control of personal emotion. By taking the victim's actions and words personally, the EMT may lose the professional objectivity needed to provide proper emergency care.

Three objectives present themselves to the EMT in providing effective crisis intervention.

1. Protection of the patient—Remember, the patient is often not able to provide personal protection from the stress of the situation. It is the responsibility of the EMT to provide this protection.

2. Protection of self—EMTs should take precautions to protect themselves when dealing with the individual in crisis. Such precautions begin with proper sizeup of the situation and assessment of the victim's emotional state. It should also be noted that protection of one's self includes assessing personal capability of dealing with the situation. If the situation is such that it is beyond the EMT's coping ability, then the EMT's interests as well as the victim's would be best served by turning the responsibility over to another EMT.

3. Stabilization of the victim—As with all emergency care, this objective is paramount. Rapid, effective intervention will assist in re-

turning the victim, as much as possible, to a pre-crisis level of functioning.

TECHNIQUE

There are any number of techniques of crisis intervention. The EMT is confronted with a unique situation because the EMT is dealing with the victim at the most crucial stage of the crisis. Further, the situation is made more difficult because the environment in which the EMT operates is often not conducive to the type of attention needed to intervene effectively. The following emergency care should be utilized for all types of intervention. It is simple enough to be adapted to most emergencies, yet effective enough to meet the demands of these situations.

1. Assign responsibility—In dealing with the individual in crisis, **only one EMT** should be assigned to deal with the intervention process. Utilizing more than one person increases the confusion of the situation and may increase the tension felt by the victim.

2. Listen actively—Listening is the key to good crisis intervention. The EMT must devote full attention to the victim. Further, the EMT should allow the victim to do most of the talking. Some important skills to be used in active listening are as follows.

- Maintain eye contact.
- Adopt a posture that communicates interest.
- Utilize "reflective" responses in the conversation.
- Listen carefully, then repeat or reflect what the victim has said. Do not repeat everything that has been said, just the general idea.
- Be honest. Nothing hurts a good, working relationship more than a lie from the EMT. Victims of crises are often hypersensitive and know when they are being told lies.

- Observe physical energy. Inactivity implies shock or depression. While the violent victim is often dangerous to the EMT, the quiet, unmoving victim is often in much more serious emotional trouble.
- Observe behavior. The crying person who claims to be "just fine" may possibly need assistance.
- Avoid judgmental statements such as "It's alright to cry" or "Start acting like an adult."

3. **Assessment**—Size up the problem by answering the following questions.

- a. What is the problem? Is the problem new or chronic (more than six weeks old)?
- b. How serious is the situation? Mild: no serious problem. Moderate: some danger involved. Severe: life or limb threatening or the possibility of psychological damage is present.
- c. What is the nature of the emergency? Interpersonal: between the person and others in the environment. Intrapersonal: within the person as a result of injury, illness or psychological dysfunction. Situational: crisis resulting from an emergency.
- d. What is the victim's level of coping? Is the victim oriented to person, place and time? (orientation x 3) Disorientation of the victim is an important factor for the EMT to note. Generally, the greater the disorientation the more unstable and, thus, unpredictable the victim will become.

Accurate assessment is vital to making proper treatment decisions. Further, this information should be noted and reported to emergency room personnel.

4. **Treatment**—The victim's interests are best served through stabilization and transportation to a safe environment (a hospital or psychiatric facility). Effective treatment begins with preplanning. The EMT should be familiar with what community resources are available to aid in the treatment of the crisis victim.

Dealing with the crisis victim is not a fast-moving process. The EMT should wait-think-respond. Nothing should be done abruptly unless the victim is in immediate danger. Waiting helps one think which increases the chance that the response will be a correct one. The EMT should always tell the victim what is going to be done before doing it. Remember, the victim may be confused and threatened. By explaining one's actions before executing them, confusion is reduced and the victim is usually more easily handled.

The EMT should avoid excessive use of restraint; the philosophy of least restraint to control the victim should be followed at all times. When restraints are used, they are to be used as humanely as possible. The EMT should **never** use restraints as a form of punishment.

In the majority of crisis intervention cases it is not necessary to provide rapid transport with lights and sirens. Such transportation often increases the victim's agitation. The EMT would be better advised to travel to the hospital at a calm, everyday pace. Finally, the EMT should always contact hospital personnel before transportation to appraise them of the situation.

CARE OF EMOTIONALLY DISTURBED PEOPLE IN LARGE-SCALE EMERGENCIES

Much research has been done in regard to behavior during large-scale disasters. In general, this research supports the notion that behavior during disasters is adaptive in nature. After years of study, researchers at the Disaster Research Center at The Ohio State University have come to a number of conclusions pertaining to behavior during disasters. The belief that wide-scale panic and wide-scale immobilizing disaster-related shock occur during these incidents has proven to be a myth. Instead, the initial behavior of the victim is one of self-help. Survivors often begin rescue efforts before professional rescue units arrive on the scene. Also, these efforts appear to follow a predictable pattern. The survivors look toward caring for:

1. Their families
2. Their neighbors
3. Their community
4. Themselves

Finally, people who would normally be repulsed by certain tasks, such as moving the dead and treating the injured, put their revulsion aside for the moment and do what is necessary.

There will be emotionally disturbed people to deal with in any disaster situation. However, such behavior will not be generalized.

The American Psychiatric Association has divided the reactions to large-scale emergencies into 5 categories.

1. Normal
2. Individual panic or blind flight
3. Depressed
4. Overly active response
5. Bodily reaction

Each EMT must understand these individual reactions to an emergency and know how to cope with them.

NORMAL REACTION

Signs and Symptoms—The experienced EMT has often seen normal reaction to emergencies. In fact, an EMT may have a normal reaction to an emergency. The signs of this reaction are trembling, profuse perspiration, nausea and weakness. A victim may be confused and experience what is sometimes called "temporary state of shock."

Emergency Care—Reassure the victims. If you encourage them often, they usually will recover in a short time. They then may be able to assist the EMT in the case of a large-scale emergency.

If a person does not show signs of recovery, that person should be removed from the scene.

BLIND FLIGHT OR INDIVIDUAL PANIC

Some laypersons describe blind flight as "running wild." Research has shown that mass panic does not occur unless means of exit appear to be closing.

Orderly Exit—It is not thought to be panic if a person or group remove themselves in an orderly way from a dangerous or supposedly dangerous situation. A good example of proper control of panic is fire drill practice in schools. If children did not practice orderly exits, many might panic in a real emergency, causing the entire class or school to panic. But, because of practice drills there is a quick, orderly, normal reaction.

Signs and Symptoms—There is a variety of symptoms of individual panic. The victim may attempt to flee from the scene. EMTs have found uninjured persons running about a scene or away from it. The victim may lose all judgment and may want to do unreasonable things at the scene which could be done later. The victim may weep uncontrollably. This sign may come on with little stimulus. For example, at the scene of a home accident someone may be

running about wildly and weeping. It may later be found that this victim is not part of the family, but a distant neighbor who happened by and reacted to the injured person in this way.

Emergency Care—Be firm but gentle at first. If the victim is so upset as to cause other people to panic, the victim should be isolated. This may require the effort of several people.

A panic-stricken victim sometimes can be isolated in the emergency vehicle or a police car. If there are injured persons involved, another vehicle should be called to take the person suffering from individual panic to the hospital. To put this victim in the same vehicle with severely injured people could increase the shock of the injured.

Upon your arrival, bringing the person with individual panic under control may have a reassuring or calming effect upon many other people. This will contribute to better patient care for all concerned.

Do not strike or throw cold water on the panicky victim. These methods have been found to be of little help.

DEPRESSED REACTIONS

Signs and Symptoms—In the midst of a bad accident scene or disaster, the victim exhibiting a depressed reaction behaves as though there is no one around. The victim seems to be "in another world". This behavior has been witnessed many times at large-scale accidents such as explosions, tornadoes, train and bus accidents, etc. The accident is more than the victim can take mentally and, therefore, the victim shuts out the world. This person may have a vacant expression, showing no emotions or may sit or stand without moving or talking.

Emergency Care—Do not rush this victim. Your contact must be gentle. Try to get the victim to talk. Ask what happened.

Finding a routine, simple job for this victim might help in bringing back normal behavior.

This person might help the EMT with simple jobs in caring for patients, such as holding a flashlight, bandages, reports, etc. In a short time this person may realize the disaster is not as great as it seemed. These victims may also realize that they are making a positive contribution by helping the EMTs.

Do not show pity or resentment toward the victim. Also, do not tell the victim to "snap out of it."

Remember, the victim in this condition does not pose a threat. Thus, this person should be given a low priority in triage unless other serious injuries are present.

OVERLY ACTIVE RESPONSE

Signs and Symptoms—This person will be exploding with energy and ideas at the scene, cannot sit or stand still and will jump from job to job, hardly finishing one. This person also may joke inappropriately, talk very rapidly and/or be argumentative.

Upon arrival, the EMT may at first think this person is being helpful, but in a short time it will be found this person's activities are useless. By insistence upon certain ideas and going from one place to another, this acutely active victim may be a source of opposition to your sound, practiced rescue and emergency procedures.

Emergency Care—People suffering from this condition are unpredictable and must be supervised closely. They should be transported away from the scene as soon as possible.

Be firm with these individuals but do not argue with them. The rightness or wrongness of your order can be dealt with later. These persons are the first to find fault with anything, and they may be very disturbing to the rescue personnel if not supervised.

Give these victims some personal attention. Talk with them for a short time. If they think they are "on your side", they will be more cooperative. Do not tell them they "should not feel the way they do."

BODILY REACTIONS

Signs and Symptoms—These reactions are different from the normal reactions described in this section. The symptoms include severe nausea and vomiting. Victims may also lose the ability to move their limbs. Loss of sight, hearing or speech may also occur. These are forms of conversion hysteria; the victims subconsciously convert their anxiety to a part of their body.

Do not assume that someone who shows symptoms of conversion hysteria is not physically injured until they have been examined thoroughly.

Emergency Care—If a victim believes that a part of the body is injured, treat it as though it is. A splint or other measures may help temporarily. Show the victim you are interested in helping.

Do not blame or ridicule the victim. Conversion hysteria is not under conscious control. Do not tell the victim there is nothing physically wrong. A victim can be **functionally** blind or paralyzed, even though the involved **structure** is uninjured.

SUMMARY

In dealing with any of the five described kinds of reactions, the EMT must establish an effective contact with the disturbed person. Once this contact is made it is reasonably easy to deal with the victim.

A victim may exhibit one reaction, and later another. The EMT must be able to care for all reactions exhibited. The following general approaches should produce positive results.

1. Introduce yourself by telling the victim who you are—an EMT, police officer, etc. Offer your first name as well as your last.
2. Ask the victim's name and then use it often.
3. In talking, use a reassuring tone. Do not shout.
4. A very primitive need dating back to infancy is the need to be touched and held. A

touch of the face and/or the hand can be very reassuring to a victim, particularly children. You can touch with your eyes as well as your hands. Look the victim in the eye when you talk. It is a good way to show you really care.

5. Accept every person's right to feelings. People do not always act **as we want** them to.

The EMT must realize that no one, including the EMT, is immune from the above reactions. Any rescuer who develops the above symptoms should be removed immediately from the scene. Finally, research has shown that rescuers often develop emotional dysfunctions in the aftermath of disasters. After the San Diego air disaster in 1977, approximately one-third of those involved in rescue efforts displayed emotional problems serious enough for them to seek professional help on a short-term basis. Remember, these problems *do* occur and they are normal reactions to the emotional overloads created by disasters.

STRESS AND THE EMT

The average person is seldom confronted with the types of emergencies an EMT encounters daily. Grievous injury, threats to personal safety and often death are the stock and trade of emergency medical personnel. This fact separates the EMT from the general population; however, it does not exclude the EMT from personal stress created by constant exposure to emergency scenes and the various risks which are involved.

The EMT is faced with everyday stress created by a job and personal life in addition to unpleasant scenes during an emergency response.

Studies have shown emergency personnel are subjected to high levels of stress on calls involving infant death, child abuse and mass casualties. EMTs are not "superhumans" and are subject to emotional strain. As an EMT experiences numerous, stressful situations on the job, it is possible to suffer a dysfunction. The dysfunction may affect the EMT physically, emotionally or in a manner involving both.

An EMT performs a critical service to the public. Therefore, it is important to maintain good health both physically and mentally. Signs of stress such as fatigue, loss of interest in a job, *failing to attend to job duties or emotional outbursts* (easily losing one's temper) should

not be ignored. Recognizing these characteristics as signs of stress is important. Once detected, they can be dealt with by seeking professional assistance. This should not be viewed as a weakness. Stress can, and does, occur in most professions.

COMMON MENTAL DISTURBANCES

There are medical conditions commonly seen by EMTs pertaining to the mentally disturbed patient that are not necessarily related to an accident. Delirium tremens, hysteria, and amnesia among the most common.

DELIRIUM TREMENS

Delirium tremens is a mental disorder involving hallucinations both visual and in hearing, commonly called "DTs."

This acute type of insanity is brought on by prolonged alcoholic drinking or a sudden withdrawal of alcohol.

Signs and Symptoms—The victim usually experiences depression, uneasiness, and insomnia for a day or two. Then severe shaking develops along with hallucinations: the "seeing" of non-existent things.

Emergency Care—Transport the victim to a medical facility offering psychiatric care at once, so as to protect the victim and those with whom the victim might come in contact. The victim may see or hear things that are not actually present and may strike out at these imaginary objects or start to run from them. EMTs should not assume the victim is striking at them.

Try to engage the victim in general conversation. While talking, move the victim into the emergency vehicle and transport. If violence is encountered, you may be forced to use restraint for the victim's protection as well as that of the EMT.

HYSTERIA

Signs and Symptoms—Hysteria is manifested in many ways. It may be as mild as a

headache, or so violent that it brings on self-destruction or personal injury.

The causes of hysteria usually stem from nervous disorders or a sudden psychological shock. Persons in a state of hysteria are usually not aware of their actions. The arrival of an emergency vehicle and the EMT may cause hysteria to become much worse. Because of this, the proper approach to hysterical patients is most important.

Emergency Care—Through speech and movements, the EMT must convey a reassuring calmness.

1. Actions should not be hasty, but deliberate and meaningful.
2. Talk to the victim softly and slowly. All motions should be slow and deliberate.
3. After talking to the hysterical patient in order to win confidence, arrange to transport the patient to a medical facility.
4. Many times, the victim will not consent to ride in an emergency vehicle, but will go with members of the family in a private car. If quiet and acting normally, allow the victim to go with members of the family.
5. If the victim is violent upon EMT's arrival, the EMT must take precautions to prevent personal harm or harm to the victim. The method of approach described above may be used to get close to the victim. As soon as the EMT is able to grasp the victim, the EMT should do

so, but first make sure there is plenty of additional help at hand.

6. The victim should receive medical help quickly.

AMNESIA

Signs and Symptoms—True amnesia victims will act very much like unconscious persons who have been suddenly awakened. These victims may be able to give their name, but will not remember anything about the past. Some victims will obviously be dazed and will recall neither their name nor their whereabouts. Furthermore, these victims will be slow to move.

The cause of amnesia may be either physical or psychological shock. Usually it is the latter.

Emergency Care—Transport the victim to the nearest medical facility. Psychological care may be needed. A physician will be able to arrange appropriate treatment for the victim.

PSYCHOTIC BREAKDOWN

Psychosis is a severe form of emotional disturbance. It involves severe disruptions of thought processes, emotions and one's sense of time and place. The psychotic individual's emotional expressions are often extreme and this individual does not recognize personal behavior as being abnormal. In most cases, a psychotic breakdown will result in behavior so unusual it will become immediately apparent to the EMT.

There are several forms of psychosis, but the primary task of the EMT is not to determine the type but the severity of the disturbance. The following symptoms are displayed by most psychotics and should immediately alert the EMT to the presence of a severe emotional disturbance.

SIGNS AND SYMPTOMS

Psychotic persons may not be aware of the time, day or date. They also might not know where they are or how they got there. Information such as the names of relatives, age, address, etc., also may be forgotten.

The psychotic person also may experience extreme emotions; being totally withdrawn or overemotional. The latter may make the victim appear uncontrollably elated or produce unsuitable reactions such as laughter at the death of a friend or relative. Also, due to a lack of coordination, the victim may verbally or physically fight with the EMT, make sexual advances or use profanity. Remember, the victim has no control over this behavior.

A lack of motor coordination is another symptom experienced by the psychotic person. Because of this, this person may repeat certain words, phrases or activities over and over; exhibit difficulty in beginning a function; remain in a certain position for a long period; and/or display constant motion, such as continual pacing.

Psychotic persons may believe they hear voices. These voices may talk to or about the victim and instruct the victim to act in some way; or the victim will "talk" with famous individuals from the past or present, such as Ben Franklin.

The victim also may experience the sensation of bugs and insects crawling beneath the skin and/or taste poison in food.

The psychotic person may strongly believe in something the EMT knows to be false. For example, the victim may believe that people are scheming to control the victim. Other ideas held strongly by the victim may include the belief that the victim has a serious illness or has committed an unforgivable act; or the belief that the victim is supposed to protect the world from disaster.

EMERGENCY CARE

Potential for aggressive behavior from the emotionally disturbed individual is minimal in most situations. However, the presence of any of the previously mentioned symptoms does increase the chance for aggressive behavior. Behavior of the EMT in controlling the situation can be a factor in the development of aggressive

behavior. Successful treatment will depend upon the attitude and behavior of the EMT. The following is a guide to intervention.

1. Make the environment safe and remove sources of stress and provocation. This includes other people. Remember, reducing the stress in the situation will decrease the chance of aggressive behavior.

2. Attempt to establish communication with the individual. Work to gain trust and gently

attempt to get the victim to respond to you. Do not carry out any action quickly or in a threatening manner.

3. Assess the degree of emotional disturbance and potential for aggressive behavior.

4. Continue intervention utilizing the methods outlined earlier in the chapter.

5. If restraint is necessary, restrain safely and be sure your actions are justified.

THE RAPE VICTIM

Caring for the rape victim can be one of the most difficult and painful experiences encountered by the EMT. In the past, our society has created many myths about rape and the rape victim. In many cases, we have been led to believe the victim enticed the assailant and somehow "asked for" the assault. Further, since rape is almost exclusively a crime *against* women it is difficult for some males in our society to understand the feelings generated by such an assault.

Research has shown these myths have done much damage to women who have been victims of rape.

Recent court decisions have rectified some of these shortcomings within the system. However, changes in the legal system are only part of the needed change. Attitudes toward the victim must also be altered. In a rape case, as in most other emergencies, the EMT is often the first to arrive at the scene. As a result it is important the EMT understand the rape victim is just that—a victim. The victim of a rape is as legitimately injured as the victim of any other emergency. Dealing with a rape situation requires a high degree of professionalism on the part of the EMT. The scene itself must be treated as a crime scene. Further, the victim must be treated with gentleness and compassion. Anything short of this may cause permanent psychological damage.

Following is a list of guidelines to follow when assisting the rape victim.

- Do not judge the victim. As far as you are concerned, the victim was raped.

- As an EMT introduce yourself to the victim. Be sure to give your title and position.

- Talk directly to the victim and ask if there are any injuries. Direct conversation with the victim will help the EMT gain information about the victim's life.

- Observe but do not touch the victim. Rape is a terrifying experience, and touching the victim may only increase fear and anxiety, unless it is done as needed medical treatment.

- If injured, ask the victim if you can provide treatment. Asking permission aids the victim in gaining some control and may make your conversation easier. Always explain to the victim what and why you are doing something before you do it.

- Do not cleanse any wounds unless absolutely necessary. Foreign matter in and around the wound may later be used as evidence against a suspect.

- Once treatment has been started, the victim should not be left alone—not even for an instant. Talk to the victim but do not joke or talk about unimportant things. Ask pertinent

questions such as, "Do you feel sick at your stomach?" Reassure the victim. Explain you will soon be transporting the victim to the hospital.

—Do not undress the victim or examine the genital area. If there is evidence of injury, pad the area with a thick dressing.

—If the victim needs to be taken to the hospital because of serious injury, transport immediately. If not, it may be best to wait for police before transporting.

—Ask the victim what is needed. You might ask, "Is there someone you would like me to contact?" Many victims ask for the police, a doctor, psychological help, security or friends or family members. Some victims will not know their needs. Try to assess the situation and accommodate these victims. Keep the victim comfortable by providing pillows, blankets, emesis basin and/or anything else requested by the victim.

—The victim should be discouraged from eating or drinking and should be told not to bathe, douche, urinate or defecate until after being examined by medical personnel.

—Do not touch the victim. Do not even give the victim your hand for comfort. This may serve only to frighten the victim. If the victim should take your hand, without you offering it, this is fine.

—Let the victim express emotion, but do not ask for details. Your job is to calm and reassure the victim of safety.

—Do not question the victim about the rape.

—Keep the victim private and away from anyone that might bother the victim.

—Secure the best possible description of any suspect and the last known direction of the suspect and give to the dispatcher. The dispatcher will relay this information to police.

—Secure the crime scene.

—The victim's physical and emotional states should be noted on the ambulance record. Be descriptive, noting if the victim "cried continually," etc.

—Explain to the victim, as much as possible, what action will take place. Then, transport the victim to the hospital. Many states have hospitals specifically designated for victims of sexual assaults. These hospitals are equipped for a rape evaluation.

—Upon arrival at the hospital, do not openly announce you have a rape victim. Simply state it is an assault victim and then quietly inform the nurse or physician of the rape. Remember: The rape victim should be treated with respect.

SUICIDE

Suicide is a serious problem. It is estimated that at least 2,000,000 people in the United States have attempted suicide at least once. Yet, suicide is one of the least understood problems the EMT will encounter in the field.

Statistics suggest that for every 100,000 people there are 110 suicide attempts per year. It is difficult to identify a given population prone to attempting suicide. It occurs in all races and exists in all cultures. It is known, however, males commit suicide three times as often as females, while females attempt suicide three times as often as males. The suicide rate is lowest among

married individuals and is highest among those individuals who are divorced or separated. In the past decade, there has been an alarming increase in suicide attempts and successful suicides within the adolescent population of our society.

There are many reasons why a person chooses suicide as a way of coping with problems. Listed below are five patterns which identify some common factors in suicide.

1. The impulsive suicide—This pattern occurs as the result of some major disappointment

such as failure at school, being passed over for a promotion, or failure to achieve some important personal goal.

2. The depressed suicide—This pattern is seen in the severely depressed individual. Often the depression is a long-standing condition and the individual sees no other alternative to the problem. In some instances these individuals are in therapy and/or on medication. Often the victim has made enough progress to realize the severity of the sickness resulting in suicide out of anger or disappointment in self.

3. Suicide as an escape from suffering—This pattern is found in individuals who suffer great physical or emotional pain. The physical pain almost always is the result of a long-standing illness that is weakening and/or terminal in nature. Pain also may be generated by an emotional disorder from which there appears to be no escape. In these situations, suicide often seems a better alternative than prolonging a life filled with pain.

4. The communications suicide—This pattern is seen in the individual who does not desire to end life, but rather change the way people treat the victim. In essence, these individuals commit the act to draw attention to themselves. Often the act is well planned and designed to inflict damage rather than death. It is not uncommon, however, for these individuals to miscalculate and accidentally kill themselves.

5. Loss of a loved one—This pattern is seen in individuals who have lost someone very close. The most common factor is the death of a loved one, but divorce and physical separation are also seen as factors in this type of suicide.

INTERVENTION

Most suicide crises present a temporary situation. Intervention to prevent suicide must be started without hesitation and carried out with great patience and flexibility. The EMT must remain nonjudgmental and non-punitive when

dealing with these individuals. Personal values cannot interfere with helping the victim.

The following techniques should be used in treating the potential suicide victim.

1. Be sure the environment is safe for the victim. If possible, move the victim to a quiet, private area. The victim should be kept from any further strain or aggravation.

2. It is important the victim trusts you. To gain this trust, identify yourself and explain to the victim that you are trying to help. One EMT, only, should be in direct contact with the suicidal individual. The second and third EMTs should be present but keep silent.

3. You should let the victim know you take the suicide threat seriously.

4. Do not argue with the suicidal victim. Instead, show you care and speak reassuringly to the victim. Saying things such as, "That must have made you feel very lonely," will show the victim it is okay to display emotions.

5. It is alright to talk about the victim's suicide attempt. Talking will build up trust between the victim and the rescuer.

6. The suicidal victim may question your honesty and willingness to help. It is important, therefore, to constantly reassure the victim of your desire to provide assistance.

7. Try to obtain additional information about the victim and the problems which led the victim to this situation. Offer comfort and support.

8. Address the main problem. If there is more than one, approach each problem separately. Try to introduce the victim to alternative solutions to these problems. Be encouraging, but do not lie. Suicidal victims are often firm in their beliefs and many times may not have considered these alternatives.

9. The victim should be immediately directed to a hospital or other safe environment.

10. In the case of a person who has succeeded in committing suicide, crisis intervention should be referred to the survivors.

In dealing with the suicidal victim, there are guidelines which must be followed and specific duties which must be done. Likewise, there are things which should *not* be done. These "do not's" are as follows.

1. Do not disregard a threat of suicide.
2. Do not dare a person to "go ahead and try it."
3. Do not say the victim's thinking is wrong. This may produce feelings of guilt, thus causing a breakdown in trust between the victim and the rescuer. It might also push the victim toward suicide.
4. Do not look for suppressed reasons behind the victim's behavior.
5. Do not move suddenly or too quickly. Assisting a suicidal individual takes time.

6. Do not take unnecessary risks.

Remember, any threat of suicide should be addressed seriously. Usually, the people who commit suicide have attempted it in the past.

Many times in the suicide situation, there is a homicidal element. A person who attempts suicide may also try to harm someone else. Therefore, extreme caution must be exercised when dealing with this person.

Another factor which must be considered when dealing with an attempted suicide is the effect of the situation on the rescuer. The rescuer is not immune to feelings of anxiety and/or fear, and such a situation might produce these emotions. If, for some reason, the suicide presents a personal problem to the rescuer, the rescuer should request assistance and allow another rescuer to take charge.

TRANSPORT OF THE MENTALLY DISTURBED

The most critical time for the EMT in handling a mentally disturbed victim is during transport. It is then the EMT's ability to make judgments is needed. At the time the victim is picked up, there possibly may be help from the victim's family, neighbors or police. At the hospital, upon delivery of the victim, assistance from physicians, nurses or staff may be available.

Many potential problems can be overcome if the following are considered.

- The question of using restraints should be discussed with the family, the victim or the police before leaving the scene.
- During transport, many times a stranger or a neighbor is a better companion than one of the family, particularly if the mental disorder has been the result of a family problem. However, common sense must prevail.

—Many mental problems are the result of brain tumors or brain injury. These individuals may go into convulsions during transit. Treat them as you would an epileptic convulsion.

—Continually reassure and calm the victim. Encourage the victim by stating you are there to help and will do all you can to protect the victim from the people and/or things the victim fears.

When transferring the mentally disturbed patient, a member of the family should accompany the EMT regardless of the sex of the patient. This will serve to protect the EMT and will reduce the stress on the patient. The accompanying person should not be allowed to ride in the patient area during transport, but should ride in the cab of the vehicle.

DRUG-RELATED PROBLEMS

Local Poison Control Phone No. _____

OBJECTIVES

Upon completion of the following chapter, you will be able to:

- describe basic drug reactions.
- describe emergency care to treat a drug overdose victim when the type of drug used is unknown.
- describe emergency care to treat a drug overdose victim according to the type of drug used.

Following instruction and/or practice, you will be able to:

- administer emergency care to a drug overdose victim when the type of drug is unknown.
- administer emergency care to a drug overdose victim according to the type of drug used.

INTRODUCTION

Drug use and drug-related problems are not a new phenomena. Drugs have been used in all societies and in every century since recorded time. Studies have shown the desire for an altered state of consciousness or "high" might be an inborn drive. For example, small children will spin until they are dizzy and fall down. This is one of many ways of achieving an altered state. Another of these is the use of drugs.

DEFINITION

Simply stated, a drug is any substance which, when taken into the body, causes a physiological or psychological change for the user. For simplicity, most food will not be included as a drug in this chapter. With this definition in mind, it is obvious that nearly everyone is a drug user and, therefore, there is no way to describe a "typical drug user." People of all ages and from all socioeconomic groups use and abuse drugs.

CARING FOR THE DRUG-RELATED VICTIM

Three basic variables determine if a person will need emergency aid as a result of drug ingestion. These are the drug itself, the setting, and the set of the drug user. As an EMT, it is important to assess each of these factors.

The **drug** itself includes such items as: what kind of drug was taken, the quantity, what else was taken with it, how pure the drug was, how often it was taken, how it was administered, and the previous drug use of the victim. It is

important to note that a person who has used a drug regularly may have built a tolerance for it and exhibit milder effects than a person using the same amount for the first time.

The **setting** or environment includes such factors as whether it is supportive or threatening, familiar or strange, roomy or cramped, tranquil or threatening, warm or cold, noisy or quiet. Other considerations are activities taking place and the time of day.

The **set** refers to the drug user including such variables as physiology, personality, motivations for using a drug, and fears. One very important factor is the expectations the person has for the drug. For example, if a user expects using the drug will result in a frightening experience, it may.

It is only when the outcome of these three is negative that the person is likely to need help. As a person entering the scene, the EMT becomes part of the setting and can be very helpful or harmful. The EMT can change the environment either positively or negatively. Certainly, the hope is that the change would be a positive one. The EMT can help the victim by: 1) being supportive instead of threatening, 2) moving the person from a crowded area to a roomy one, 3) changing the atmosphere from confusing to tranquil, or from noisy to quiet, 4) regulating the temperature.

The EMT can also be helpful in changing the user's set by such means as reassuring the person of living and the rightness of seeking emergency aid. The EMT should also explain to the victim that the victim is feeling the effects of a drug. Remember, however, that unlike other emergencies, a drug-related victim is likely to have mixed feelings about your presence. Though the person will likely be relieved to have medical help, the EMT's presence may be feared or resented as the person may associate the EMT with the legal system.

In conclusion, more so than any other victim, your approach to the drug-related victim can spell the difference between an extremely agitated, uncooperative victim or a subdued, cooperative one. Be non-judgmental, gentle and caring—don't be afraid to touch the person with your hands or eyes; use force and/or restraints only as a last resource.

TREATMENT OF THE DRUG OVERDOSE VICTIM

The victim of a drug overdose can be treated in two ways: by the symptoms exhibited and by treating according to the specific drug taken. Because over 50 percent of the drugs sold on the street are misrepresented or altered, it is best in most circumstances to treat the person according to the symptoms. Only after treating according to symptoms should the EMT treat according to the drug taken.

TREATMENT BY SYMPTOMS

Treating a drug-related victim by symptom is no different than treating a non-drug-related victim. As with any other victim, the initial assessment should include breathing rate, pulse, blood pressure and possibly temperature. It is also important to note neurological indicators including such items as level of consciousness, coordination and speech, and abnormalities of the eyes. Observe if the eyes are glazed, dull, dilated, or pinpoint. Unequal pupils are NEVER caused by drugs. In such situations, suspect brain injury.

The drug-related victim may exhibit various symptoms discussed in previous chapters. Obviously, if warranted, CPR should be started at once. If the drug was taken by mouth, treat as explained in the chapter on Medical Emergencies. Also present may be shock, hyperventilation, unconsciousness, convulsions, anaphylactic shock, and allergic reactions. The victim should be handled as anyone else with these symptoms.

Additionally, drug-related victims as well as non-drug related ones may have panic and anxiety reactions. It is important you remain **calm** and talk **slowly**. Again, reassure the person of living. Also explain that seeking medical help was correct. **Use the person's name while speaking in simple phrases and sentences.** Be warm and friendly and nonjudgmental. Do not become paralyzed if you make a mistake. Do not try to be a counselor at that point. **Avoid tricks or sudden actions.** Remember, the person may be feeling quite frightened.

TREATMENT ACCORDING TO THE DRUG TAKEN

After treating a victim of a drug-related problem according to the symptoms exhibited and if very sure of the drug taken, treat the person according to the specific drug.

Drugs are commonly broken into four categories: the central nervous system depressants, the central nervous system stimulants, the opiates and opioids, and the hallucinogens. Some

drugs such as aspirin and aspirin substitutes, marijuana, hashish, PCP, and inhalants do not fit well into any of these categories and will be discussed in separate sections. Each of the following sections will explore the effect of the classifications, examples, overdose effects and symptoms, and treatment over and above the treatment by symptoms.

DEPRESSANTS

Central nervous system depressants include alcohol, barbiturate sedative hypnotics, non-barbiturate sedative hypnotics, and the minor tranquilizers.

ALCOHOL

As alcohol is legally sold and socially accepted, most people do not think of it as a dangerous drug. This simply is not true. Alcohol is responsible for more deaths than all other drugs combined; it is involved in at least half of all auto deaths, one-fourth of all murders and a quarter of all suicides. Obviously, alcohol is a very dangerous drug.

By classification, alcohol is a central nervous system depressant which affects nearly all body systems. Though initially a person using alcohol may appear talkative and stimulated, these effects are a result of alcohol's ability to depress inhibitions causing a user to do and say things not normally done or said.

BARBITURATES

Introduced in the early 1900s, the barbiturates are still widely used and abused. Common trade names of the barbiturates include Seconal, Nembutal, Tuinal, and Amytal. They are sold on the streets under many names including reds, yellows, rainbows, blues, and tuies.

Although legally prescribed by physicians, barbiturates bought on the street are often altered. Even capsules with pharmaceutical markings can be opened and the contents replaced with anything from a laxative to a stimulant to

no active ingredients. Drug dealers are not known for their honesty.

SEDATIVE

Due to increased public attention to the dangers of barbiturate sedative hypnotics (sedative referring to relaxation, hypnotic to sleep-producing), non-barbiturate sedative hypnotics were introduced to replace the barbiturates. These include such trade name drugs as Doriden, Placidyl, Equanil, and Miltown; as well as the very popular generic drug, Methaqualone, sold under the trade names of Quaalude, Sopor and others. Though these drugs are non-barbiturate, the user of such drugs exhibits very similar symptoms.

TRANQUILIZERS

In an attempt to produce a barbiturate-like drug without inducing sleep, the minor tranquilizers were introduced. Such popular trade name drugs as Valium, Librium, Dalmane, Tranxene, and Serax produce similar effects to the non-barbiturate sedative hypnotics.

With only slight differences in effects, the minor tranquilizers were manufactured to replace the non-barbiturate sedative hypnotics which were to replace the barbiturates, which were to replace alcohol.

OVERDOSE—SIGNS AND SYMPTOMS

Though similar in individual effects, the depressant drugs, when taken in combination, often produce a phenomenon called drug synergism. Especially dangerous is any of the other depressants mixed with alcohol. A combination can be fatal with death usually occurring from respiratory depression. This phenomenon occurs because the liver is unable to "detoxify" both drugs at once. Although the liver is the organ responsible for this "detoxification" process, it can process only one drug at a time. As the liver processes alcohol first, the other depressants are allowed to recirculate in the body unprocessed. Therefore, the effects of one part alcohol and one part of other depressant do not equal two, but many, many times that amount. This combination is the number one source of drug overdose deaths.

Though the drug names may be different, depressant overdose victims exhibit similar behavior and physical symptoms. The victim may appear disoriented, confused, sleepy, and possibly aggressive. The physical symptoms may include lowered blood pressure; slow and/or ir-

regular breathing and pulse rate; weak or non-existent reflexes; slurred or slow speech; glazed eyes with slow reaction to light; vomiting; and pale, dry skin.

EMERGENCY CARE

To treat a depressant overdose victim who is awake, dilute the drug with several glasses of water or milk, induce vomiting, and dilute again with water or milk. Keep the victim on side to avoid aspiration of the vomitus. Monitor the vitals closely for changes or deterioration. Protect the person from personal injury or injuring others. Keep the victim awake to avoid a comatose state. However, **NEVER** give the person coffee or other stimulants. If coffee is given and some of the drug is still in the stomach, the coffee will speed the dispersion of the drug and cause the condition to worsen. Additionally, stimulant and depressant drugs are not opposites and do not cancel each other. A person given both of these will continue to exhibit symptoms of both drugs, a much more serious and potentially deadly condition than either alone.

OPIATES AND OPIOIDS

DEFINITION

Opiates are any of the drugs containing opium or its derivatives. Opiates are commonly referred to as narcotics which simply means painkillers. These are the best and safest pain relievers available and are often prescribed by doctors. Opioids are synthetically derived drugs made to mimic the effects of the opiates.

The opiate user who is using a pure, unaltered drug is a harmless person. Alarmists paint a picture of an opiate user as a stealing, murdering, raping, crazy person as a result of the use of the drug. This simply is false. Only to maintain the drug-using habit does the user turn to such extremes. Additional problems arise with the drugs being altered with virtually anything. Most heroin sold on the street is less

than 10% pure with the other 90% being additives.

Opiates include heroin, codeine, morphine and opium. Some street names for heroin include smack, junk, "H," and horse; "O" for opium; Number 3's or 4's for codeine; murphy and morph for morphine; and percs for percodan. Again, it is almost impossible to present any composite list of street names of drugs. The opioids include such trade names as Darvon, Talwin, Demeral, Methadone and Percodan.

SIGNS AND SYMPTOMS

In non-overdose quantities the user will appear drowsy and euphoric with a loss of pain perception. In overdose quantities the user will

appear semi-conscious or unconscious with the condition deteriorating—especially if the victim becomes unconscious.

OVERDOSE

The most serious overdose symptom is respiratory depression. Other physical symptoms include constricted or pinpoint pupils, itching skin, vomiting and nausea, runny nose, constipation, cyanotic and moist skin, slow pulse (though it may sometimes be rapid early in the overdose), and high or very low blood pressure.

EMERGENCY CARE

After treating the victim by symptoms, if the

drug was taken orally, dilute the drug with several glasses of water or milk, induce vomiting and dilute again with water or milk. Support the person with oxygen if warranted while closely monitoring the vital signs as the condition may deteriorate rapidly, especially if the person sleeps. Therefore, keep the person awake and talking. Maintain a clear airway and, if unresponsive, place the victim in "coma" or lateral position. This will help avoid aspirating the stomach contents if the person vomits.

STIMULANTS

DEFINITION

Central nervous system stimulants include a variety of substances used to decrease the appetite, combat fatigue and drowsiness, and generally make the user feel high.

In the 1960s amphetamines were used both legally and illegally. Due to stiff controls, pharmaceutically made amphetamines are less common on the streets today. The three most common trade names are Benzedrine (bennies, black beauties), Methadrine (speed, crystal), and Dexadrine (dexies, Christmas trees).

Additionally a variety of non-amphetamine "diet pills" are available both by prescription and over-the-counter.

Cocaine, derived from the coca leaves, was the first "speed" drug used in the United States, dating back to the early 1800s. Though its effects are similar to other stimulants, its legend makes it a much sought after and expensive drug. Strictly an illegal drug, it has a number of street names such as coke, snow, Bernice, and white girl.

Caffeine (found in colas, coffee, tea and cocoa) and nicotine (found in cigarettes, cigars, snuff and tobacco) are also central nervous system

stimulants that rarely, if ever, produce emergency situations.

OVERDOSE

Although a true overdose of stimulants is rare unless large amounts are injected, an emergency situation can arise from use of excessive amounts or long-term use of stimulants. Behaviors in such situations may include anxiety, paranoia, or panic; fainting or unconsciousness; occasionally confusion and hallucinations; and possible aggression.

SIGNS AND SYMPTOMS

The person may exhibit any or all of the following physical symptoms: rapid breathing; rapid, bounding pulse; muscle tension; headache; dry mouth; normal to dilated eyes; warm, moist, flushed skin; high blood pressure and possible fever; tremors; heart palpitations, on rare occasions leading to convulsions; circulatory collapse and death.

Though most of the above symptoms are rarely life threatening, other complications may occur such as stroke, malnutrition, and heart damage from prolonged use.

EMERGENCY CARE

To treat a victim who has overdosed on a stimulant, if taken orally, dilute with several glasses of water or milk, induce vomiting and dilute again with several more glasses of water or milk. Minimize stimulating environmental factors by subduing light and noise. Attempt to keep the victim stationary while doing so yourself. Avoid scaring the person while taking

vital signs but monitor the vitals closely. In rare cases the temperature may rise so high as to create a life-threatening situation. Encourage the person to drink fluids but watch for vomiting and aspiration. Above all, do not become afraid or aggressive even though the victim may exhibit these characteristics. Use restraint as a last resort.

HALLUCINOGENS

DEFINITION

Hallucinogens, or psychedelics as they are often called, include a wide variety of substances. Unlike the preceding drug groups, the effects of the hallucinogens are not as well understood. Research shows these substances probably produce their effects by altering the message sent from external stimuli to the brain and also from the brain to various body systems. Due to the great variety of hallucinogens, it is difficult to cover in this chapter the effects of specific ones. In general, with these substances, users experience altered sensory perceptions in the form of hallucinations, delusions, and illusions. In some instances, sensory crossover occurs with the user "seeing" music and "hearing" colors.

Some of the more common hallucinogens are LSD (acid); jimson weed; psilocybin from the psilocybian mushroom (mushroom, magic mushroom); mescaline, the active ingredient in the peyote cactus button (mes, peyote); MDA; DMT; and STP. The latter four are rarely seen on the streets and are probably actually LSD or PCP which will be discussed later. Additionally, morning glory seeds, nutmeg, and coleus plants have hallucinogen properties but a person is

rarely able to ingest enough to get high with these.

OVERDOSE

Physical overdoses do not exist with the hallucinogens, although a hallucinogen "bummer" or "bad trip" can be a frightening situation. The effects of the hallucinogens are primarily in mood alteration, while the person maintains normal or near normal vital signs. The person who has a bummer may appear agitated or withdrawn, anxious, panicky or possibly depressed. This person also may have frightening hallucinations.

SIGNS AND SYMPTOMS

Physical symptoms (usually a result of fear and anxiety) may include dilated eyes, flushed and sweating skin, possible hyperventilation, rapid pulse, elevated blood pressure, nausea and stomach cramps, and slightly elevated temperature.

EMERGENCY CARE

As these symptoms are not physical in origin, treatment for a person having an hallucinogen bummer should be treated as explained under panic and anxiety reaction.

ASPIRIN

SIGNS AND SYMPTOMS

Though there is no real "high" with aspirin, except possibly the alleged high teen-agers used to claim from its mixture with colas, overdose—especially in young children—is a real danger.

The person will appear restless and light-headed. Physical symptoms will include nausea, vomiting, elevated temperature, hyperventilation, tinnitus (ringing in ears), pale and wet

skin, and urinary retention. In late stages the respiration will be depressed, urine output will stop, the person will become unconscious, and the person may vomit blood as a result of internal stomach bleeding.

EMERGENCY CARE

To treat the aspirin overdose, dilute with water or milk, induce vomiting, and dilute again with water or milk. Support with oxygen.

ASPIRIN SUBSTITUTES

DEFINITION

Aspirin substitutes such as Tylenol and Datril are analgesics or painkillers. Like aspirin, there is no real "high" with them but very serious liver damage can result from an overdose of them.

SIGNS AND SYMPTOMS

In early stages, the victim may complain of an upset stomach; nausea; vomiting; loss of appetite; and pale, wet skin. In later stages, though the initial symptoms may disappear, the victim

may have pain in the upper right quadrant and possibly jaundice. If the condition goes untreated, the victim may lapse into coma and eventually die.

EMERGENCY CARE

To treat, dilute with several glasses of milk or water, induce vomiting, and dilute again with milk or water. Transport to the emergency room at once. This is a very serious situation, especially if the victim is exhibiting symptoms of the later stage.

MARIJUANA AND HASHISH

SIGNS AND SYMPTOMS

Marijuana and its more concentrated form, hashish or hash oil, rarely present symptoms severe enough to be treated by an EMT. A true overdose does not exist. Problems with these substances are generally caused by an emotional reaction. The person in this condition may appear quiet and withdrawn or anxious and pan-

icky. This person also may hyperventilate or exhibit signs of shock with fainting possible.

EMERGENCY CARE

Treatment for these victims includes treatment for shock, if warranted, and reassurance. In severe situations, the EMT should treat the victim for panic and anxiety reactions.

INHALANTS

DEFINITION

Nearly anything can be inhaled to produce a "high." Due to the vast numbers of such substances, only the most common ones will be mentioned in this chapter. Toluene-based glue is the substance most people think in terms of sniffing, though the scare stories about it of the 60s were grossly exaggerated. Today glue sniffing has decreased, possibly as a result of those stories but more so because toluene has been removed from most glues. Some additional inhalants are acetone, benzene, gasoline, lighter fluid and paint—all known as volatile substances. Additionally, other inhalants include all types of aerosols including hair spray, deodorant, insecticides and frying pan lubricants.

SIGNS AND SYMPTOMS

A person who is high on an inhalant usually reports feeling giddy and euphoric, as if floating. In an overdose amount, however, the user may

exhibit signs of panic, anxiety, confusion and aggressiveness. Physical symptoms may include bloodshot eyes, nausea, coma, convulsions and cardiac arrest after physical stress. These symptoms can be intensified with severe physical stress. Additionally, with oily products such as frying pan lubricants, users may have severe respiratory problems due to the substance's coating of the lungs.

EMERGENCY CARE

Treatment for inhalant overdose includes getting the person to fresh air and/or supporting with oxygen, treating severe emotional responses as outlined in panic and anxiety reactions, remaining calm and transporting calmly. If the inhalant was an aerosol, lead paint, petroleum product, or carbon monoxide, monitor the victim carefully as complications can be fatal.

PCP

DEFINITION

PCP (Phencyclidine or Sernyl) was originally developed as an anesthetic for humans. Due to its unpredictable effects; however, it was soon discontinued for this purpose and is currently, though rarely, used only as an animal tranquilizer.

PCP first appeared as a street drug in 1967, but its popularity ended quickly because of its unpleasant side effects. In the 1970s, it reappeared but was usually masquerading as other drugs as it is cheap and easy to manufacture. It is often misrepresented as THC (the active ingredient in marijuana), mescaline, LSD, psilocybin and a number of others. More recently, it is often sold for what it is.

Sold under such street names as angel dust, dust, elephant tranquilizer, hog, T and crystal, PCP is a very unpredictable substance which

reportedly has been linked to hundreds of murders, suicides, and accidental deaths. Though most users report feelings similar to being drunk and uncoordinated, the user may become extremely agitated and aggressive, often having amnesia of the experience afterward. Added complications occur when PCP is mixed with alcohol or other depressants because additive or synergistic effects occur.

SIGNS AND SYMPTOMS

A person who has ingested, injected or smoked large quantities of PCP may exhibit any or all of the following behaviors: loss of coordination, hallucinations, fear, anxiety, aggression, and rapid mood swings. Physical symptoms may include insensitivity to pain, numbness, jerking eyes, sweaty skin, irregular breathing, hyperventilation, muscle rigidity, and respiratory

depression, if mixed with alcohol or other depressants.

EMERGENCY CARE

Treating a person who has taken a large amount of PCP is difficult as the person may be unable to be "talked down" as with the hallucinogens. However, the following procedures may prove to be helpful. Minimize external stimuli, keep the person calm, avoid

frightening the person while taking the vitals, check for mixture with alcohol or other depressants, treat for hyperventilation or administer oxygen as needed, keep the person from harming self or others, transport to the emergency room if unable to arouse or if other severe signs of intoxication exist, and use restraint only as a last resource. Note that a sudden drop in vitals may indicate the onset of cardiac arrest. In such situations, transport immediately.

CONCLUSION

As a reminder, it is important to remember that above all a drug overdose victim is a person—not just an alcoholic, junkie, druggie, or pot-head. Treat the person in a gentle, caring way. Your anger, hostility, lectures and therapy while the person is "high" are not only non-productive, but may be quite harmful. However,

it may be helpful to suggest to friends and relatives of the victim that the person be sent to the local drug treatment center for counseling after recovery. Most cities have mental health centers and/or 24-hour crisis centers. It may be useful to become familiar with such services offered in your area.

Available EMS Publications

For ordering and pricing information contact:
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The Ohio State University
154 W. Twelfth Avenue
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Emergency Victim Care—Student Manual (EVCN)
Emergency Victim Care—Instructor Manual (EVCIM)
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